MEDICAL CLAIM FORM

ELECTRICAL WELFARE TRUST FUND

10003 Derekwood Lane - Suite 130 - Lanham, MD 20706
Fax: 301-731-1065 • info@ewtf.org

IMPORTANT: Claims MUST be filed within one year or they will be denied.
Attach provider's insurance form (i.e., superbill, HCFA form)

INQUIRIES PHONE:
(301) 731-1050
Have all papers available when you call.

THIS SIDE MUST BE COMPLETED BY THE MEMBER

PART A
Member Information

The Eligible Electrical Worker's **Identification Number:**

___ ___ ___ ___ ___ ___

Member Name _____
Last First Initial

Home Address _____

_____

Home Phone _____ Work Phone _____ Cell Phone _____

Email address _____

Member DOB ____/____/____ Employer _____

Marital Status circle one: Married Single Separated Divorced Widowed

PART B
Patient Information

Definition of a Dependent:
Your lawful spouse that resides with you, and any children under age 26. For more information about dependents see the Plan booklet

Patient Name _____ Birthdate ____/____/____ Marital Status _____

Relationship to Member _____

Patient address _____

Does patient have other health coverage? Circle one: Yes No Attach copy of EOB
If yes, identify:

_____

Telephone Number _____

Is patient covered under Medicare? Circle one: Yes No
If yes, attach Medicare Explanation of Benefits from carrier.

PART C
Authorizations

I verify that all information contained in this form is true, correct and complete to the best of my knowledge.

To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

Under the privacy provisions of the Health Insurance Portability and Accountability Act of 1996, you may be required to complete a separate Authorization Form, or Personal Representative Form (in the case of a non-spousal representative).

PRINT NAME _____ DATE _____

Signature of Participant/Guardian _____

Assignment of Benefits

Is payment to be made directly to Provider ____YES ____NO

If provider of service shows assignment and balance due, payment will be made to provider. If no assignment is checked, payment will be made to provider.

If your claim is the result of an accident or injury, fully complete the back of this form.

PART D

If the patient's visit to a doctor, emergency room, urgent care center or other facility is the result of an accident or sudden illness, please provide the following information.

Date of Injury/Accident/Onset:

Was a Police Report Filed:

YES (attach copy of report) NO

Location of the Accident or Where the Injury Occurred (provide complete address)

Describe the accident fully or how the injury occurred (attach a separate sheet of paper if necessary)

List any other individuals involved:	Name of their Insurance Co.	Insurance Co. Telephone No.

Name & Address of your Insurance Company:

Will medical expenses be provided by anyone (an insurance company or individual) **other** than you?

❑ NO ❑ YES – List Names _____

_____

_____

NOTE: No benefits are payable for work-related injuries or illnesses or for injuries that are caused by a third party such as another motorist.

The rules of this plan provide that the responsible third party, or the injured person's private insurance, such as homeowners or motor vehicle insurance, be primarily responsible for payment for medical expenses and lost time. This plan will "advance" or "loan" benefits to pay bills as they come in. Any "advances" or "loan" of benefits are to be repaid to EWTF once the third party, whether an individual, employer, or insurance company has made payment. To secure such repayment, EWTF requires that the individual and their attorney, if any, sign a promissory note and repayment agreement before benefits are advanced.

I hereby certify that these statements are complete and true.

Signature _____ Date _____

Notarization is required ONLY for motor vehicle accidents and Workers Compensation.

County of: _____ State of: _____

On this _____ day of _____ , _____, personally appeared before me

_____ , who, being duly sworn, subscribed to the foregoing in my presence.

Notary Public _____ seal